

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10380 CERTIFICATE OF DEATH

10370

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 SHAFFERS NURSING HOME</u>				d. STREET ADDRESS <u>ROGERS AVE RT 3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRIS WOODWARD BEDISH</u>				4. DATE OF DEATH Month Day Year <u>OCT. 12, 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1901</u>	9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>LOUISIANA, KENTUCKY</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>JOHN F WOODWARD</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE LOVELACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>1</u>			
17. INFORMANT <u>Mrs. OTTO COTT, BETHESDA, MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-11</u> , 19 <u>56</u> , to <u>10-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-12-56</u> , 19 <u>56</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Peter V Thorpe</u> M.D. <u>COLUMBIA RD</u>							
PHYSICIAN'S NAME (Type) <u>PETER V THORPE MD</u>				<u>ELLICOTT CITY, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. CHILDS BATHOM, ELLICOTT CITY, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>			

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

OCT 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, exhumation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10381

CERTIFICATE OF DEATH

Reg. Dist. No.

1037191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Annapolis Road				d. STREET ADDRESS Old Annapolis Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARRY THOMAS GERWIG			4. DATE OF DEATH Month Day Year October 12, 1956 19				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Gerwig			14. MOTHER'S MAIDEN NAME Ardella Grimes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Daisy Gerwig, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis & left hemiparesis (11 mo.)							INTERVAL BETWEEN ONSET AND DEATH minutes years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 8 , 1955, to Oct. 11 , 1956, that I last saw the deceased alive on Sept. 12 , 1956, and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ellicott City, Md. Oct. 12, 1956							
ACTUAL SIGNATURE Donald E. Fisher M.D.		PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR Oct 16 1956		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

OCT 16 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10382

CERTIFICATE OF DEATH

10372

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. LENGTH OF STAY IN 1b <u>240</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HIGHLAND MANOR CONVS. HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHRISTIAN</u> First <u>J.</u> Middle <u>H.</u> Last <u>HEROLD</u>				4. DATE OF DEATH <u>OCT.</u> Month <u>23</u> Day <u>1956</u> Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 3, 1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TYPESETTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ANTHONY</u>				14. MOTHER'S MAIDEN NAME <u>MARIE SCHAFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MARIE SCHAFER</u> Address <u>413 N. ROSE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>56</u> , to <u>10/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5226 BACT. NAT. PK</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Max J Miller</u>				M.D. <u>5226 BACT. NAT. PK</u>			
PHYSICIAN'S NAME (Type) <u>MAX J MILLER MD</u>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY RED ECHER CEM.</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BDABROWSKI 2818 E. BALTIMORE ST.</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. B.

11 25 1956

RECEIVED

10383

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Orange			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN lb 14 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaeffers Conv. Home				d. STREET ADDRESS 18 Riverview st.			
3. NAME OF DECEASED (Type or print) First AGNES Middle RUSSELL Last JOCELYN				4. DATE OF DEATH Month October Day 24 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret)				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ? Abracombrie				14. MOTHER'S MAIDEN NAME (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT 203 Hammonds Ferry Rd Mr. Alden Jocelyn Linthicum Heights, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease						INTERVAL BETWEEN ONSET AND DEATH 2 hrs not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-22 , 19 56 , to 10-24 , 19 56 , that I last saw the deceased alive on 10-22 , 19 56 , and that death occurred at 3:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter V Thorpe M.D.				ADDRESS (Street, city or town, state) COLUMBIA RD			
DATE SIGNED							
PHYSICIAN'S NAME (Type) PETER V THORPE MD.				ELICOTT CITY MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29/56		22c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Richard L. Singleton				ADDRESS 1800 Beech St. Md		24a. REC'D BY REGISTRAR DATE NOV 29 1956	
24b. REGISTRAR'S SIGNATURE J. E. Long							

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CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1910		Boston, Mass.	
Cause of Death		Manner of Death		Date of Death		Place of Death		Physician's Name	
Heart Disease		Natural		Jan 20, 1955		Home		Dr. Smith	
Time of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Burial Officer	
10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 29 1956

RECEIVED

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 190...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>St Marys</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>Elkridge (Howard)</u>	<u>1 mo</u>	<u>Hollywood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>7220 Elmwood</u>		<u>Elkridge 27 md</u>	<u>186-2</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Annie</u>	(Middle) <u>Marich</u>	(Last) <u>Joy</u>	<u>Oct 16 1938</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>Apr 5 - 1876</u>
9. AGE last birthday: <u>80</u> yrs.	10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>House wife</u>	11. BIRTHPLACE (State or foreign country): <u>St Marys Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>William Henry Dean</u>		14. MOTHER'S MAIDEN NAME: <u>Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Sherman Joy, Hollywood Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>apoplexy</u>			<u>6 days</u>
ANTECEDENT CAUSE (B) <u>arterial hypertension</u>			<u>54/20</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chromococcalitis</u>			<u>1 yr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>			<u>1 yr</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 15 1938</u> to <u>Oct 16 1938</u> that I last saw the deceased alive on <u>Oct 16, 1938</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.			
SIGNATURE <u>W. B. Brumbaugh</u>		DATE SIGNED <u>10/16/38</u>	
M.D. <u>3609 Shuman St</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/19/38</u>	
NAME OF CEMETERY OR CREMATORY <u>Wayman</u>		LOCATION (City, town, or county) <u>Hollywood Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>October 16, 1938</u>		REGISTRAR'S SIGNATURE <u>W. B. Brumbaugh</u>	
24. FUNERAL DIRECTOR <u>W. B. Brumbaugh</u>		ADDRESS <u>Leonardtown</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 18 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10375

10385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge</u>		LENGTH OF STAY (In this place) <u>Many years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>5518 Main St.</u>			
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 4th 1956</u>
<u>FRANK</u>		<u>JOSEPH</u>	<u>PETRLIK</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1884</u>	9. AGE last birthday <u>72 yrs.</u>	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe maker</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
13. FATHER'S NAME <u>Jacob Petrlik</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>213-20-0685</u>		17. INFORMANT AND ADDRESS <u>Ann M. Petrlik, Elkridge, Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Prostatectomy to live</u>				<u>3-4 months</u>	
Antecedent cause(s) (b) <u>Carcinoma of prostate</u>				<u>3 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic heart disease & cerebral</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis and atelectasis</u>				<u>18 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov, 1945, to Oct, 1956, that I last saw the deceased alive on Oct 3, 1956, and that death occurred at 11:20 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James P. T. M.D.Rt 27, MdOct 4th 56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>10-10-56</u>	<u>St. Augustine</u>	<u>Howard Co. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
		<u>Howard J. Hubbard, 4107 Wilkens</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



10386

CERTIFICATE OF DEATH

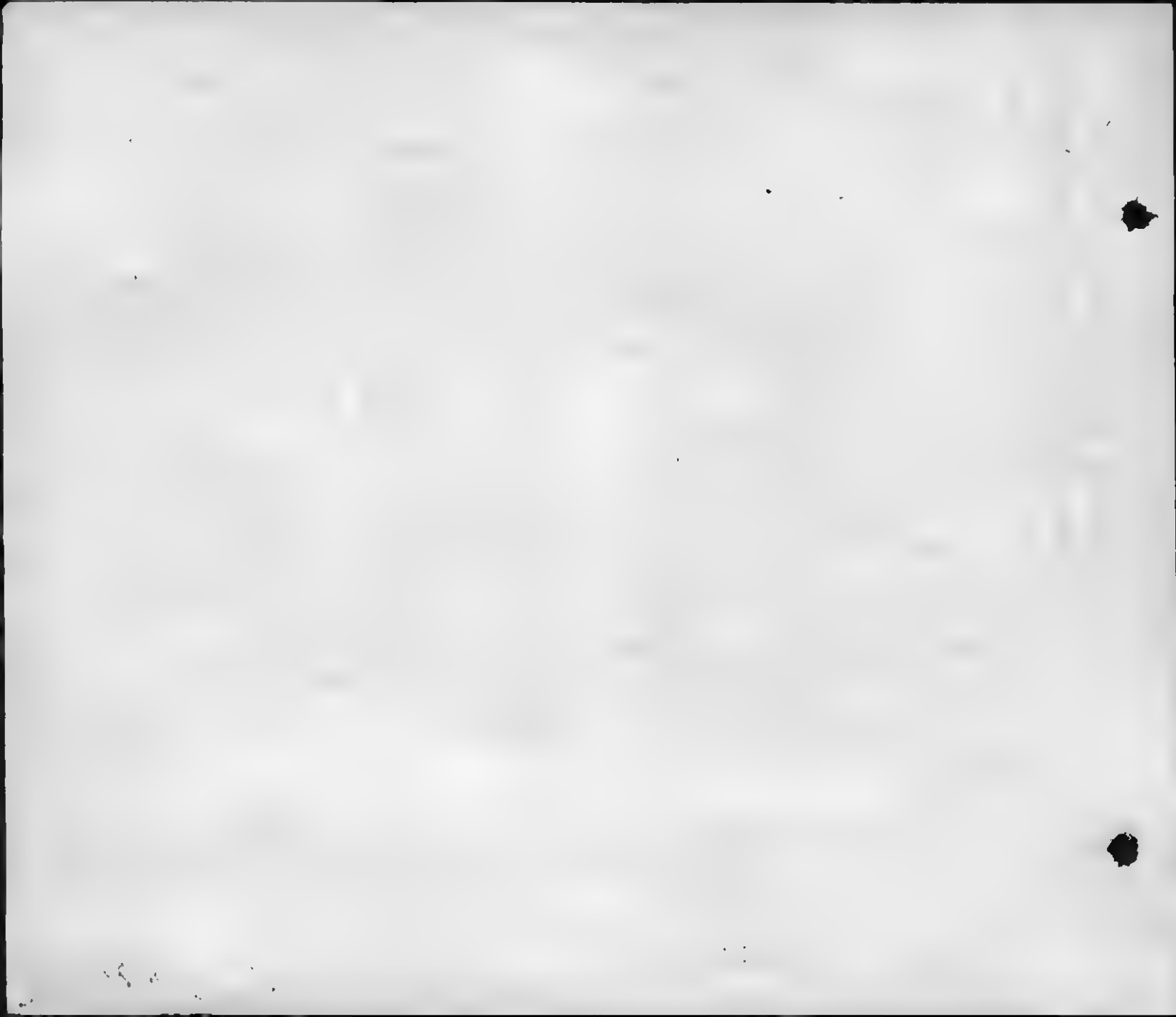
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS. A15-10-3

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Beltsville</u>	LENGTH OF STAY (In this place) <u>6 1/2 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Beltsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>22000 York Rd</u>		STREET ADDRESS (If rural, give location) <u>22000 York Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 6 1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-18-77</u>
9. AGE last birthday: <u>78</u> yrs.		10. CITIZENSHIP: <u>U.S. born</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John J. Brown</u>		14. MOTHER'S MAIDEN NAME: <u>Barbara Miller</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-09-0579</u>	
17. INFORMANT & ADDRESS: <u>Anna J. Brown, York Rd</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Heart coronary artery disease</u>			
DUE TO <u>1956</u>			
ANTECEDENT CAUSE (B) <u>Chronic heart disease</u>			
DUE TO <u>1956</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>703.0</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of hip</u>			
19A. DATE OF OPERATION: <u>Oct 2, 1956</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY: Home, farm, factory, street, office bldg., etc. <u>Home</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Dorsey, Howard, Md</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? <u>Fell down stairs</u>			
22. I hereby certify that I attended the deceased from <u>Jan 2, 1976</u> to <u>Oct 6, 1956</u> , that I last saw the deceased alive on <u>Oct 6, 1956</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Anna J. Brown</u>		DATE SIGNED <u>10/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 10, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Gion Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 8, 1956</u>		REGISTRAR'S SIGNATURE <u>Henry W. Jenkins</u>	
24. FUNERAL DIRECTOR <u>Henry W. Jenkins</u>		ADDRESS <u>Howard Co. Md</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10387

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Convalescent Home</u>				d. STREET ADDRESS <u>526 N. Loudon Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>H.</u> Last <u>Sewell</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26, 1888</u>	
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond, Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>Sidney Herndon</u>				14. MOTHER'S MAIDEN NAME <u>Frances Rives</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <u>----</u>		17. INFORMANT Address <u>M. Edward Sewell-1764 Stanley Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Oct. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>56</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. W. Kochman</u>				ADDRESS (Street, city or town, state) <u>1037 N. Calver St. Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. W. A. Kochman</u>				DATE <u>10/2/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				ADDRESS <u>4600 Liberty Hghts. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>10/5/56</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

CERTIFICATE OF DEATH

Reg. Dist. No. 10378

10388

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>SAME</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARDING RD</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMOS ELLSWORTH SOUDER</u>		4. DATE OF DEATH Month Day Year <u>OCT 13 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE T SOUDER</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCES MURPHY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-8844</u>	
17. INFORMANT Address <u>LOIS SOUDER - WIFE - SAME ADDRESS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/12/56</u> , 19 <u>56</u> , to <u>10/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>56</u> , and that death occurred at <u>2:05</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Buell</u>		ADDRESS (Street, city or town, state) <u>402 Main St. Laurel Md.</u> DATE SIGNED <u>10/13/56</u>	
PHYSICIAN'S NAME (Type) <u>John R. Buell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Seagoville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Sanatdon, Laurel Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> 24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. 3

OCT 19 1956

RECEIVED

10389

CERTIFICATE OF DEATH

Reg. Dist. No.

197

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA BELLE STANSFIELD</u>		4. DATE OF DEATH Month Day Year <u>October 29 1956</u>	
5. SEX <u>sf.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Millard E. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Frances Shipley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Oscar Stansfield - Woodstock, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Coronary Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, pyelonephritis, Cystitis</u> DUE TO (c) <u>Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> 19 <u>54</u> to <u>Oct 29</u> 19 <u>56</u> , that I last saw the deceased alive on <u>29 Oct</u> 19 <u>56</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>29 Oct 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-31-56</u>	<u>Mt. View</u>	<u>Howard, Co., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight - Sykesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>V 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Alice Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 2 1936

RECEIVED

10390

CERTIFICATE OF DEATH

10380

Reg. Dist. No. 14

1 PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Route # 144</u>	
3 NAME OF DECEASED (Type or print) <u>EFFIE</u> First <u>MARY</u> Middle <u>THOMAS</u> Last		4. DATE OF DEATH <u>October 25</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1884</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>
13. FATHER'S NAME <u>James H. Bond</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>John A. Thomas - Cooksville, Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Coronary Thrombosis, 331X</u> DUE TO (b) <u>Hypertension, Cerebral vascular</u> DUE TO (c) <u>accident (at side).</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>Oct. 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 25</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>10-26-56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>10-26-56</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Ween</u>

BUREAU V. S.

OCT 29 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

192

10391

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>			
c. LENGTH OF STAY in 1b <u>50 years</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>WAYNE</u> Last <u>WAYS</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk -</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Ways</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>McGeorge B. Ways - Mariottsville, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Oct 24, 1956</u> , to <u>Oct 31, 1956</u> , that I last saw the deceased alive on <u>Oct 30, 1956</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Randallstown, Md</u> DATE SIGNED <u>11/1/56</u>							
ACTUAL SIGNATURE <u>Wm. E. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>WM. E. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Springfield, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>NOV 7 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Miss Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

BUREAU V. S.

NOV 7 1956

RECEIVED

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor</u>				d. STREET ADDRESS <u>13 Mallow Hill Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry F. Wiesner Jr.</u> First Middle Last				4. DATE OF DEATH <u>10/23/56</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/1872</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wiesner</u>				14. MOTHER'S MAIDEN NAME <u>Greengard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Edwin P. Wiesner Jr.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Chronic Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cardiac Failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>56</u> to <u>10/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>56</u> , and that death occurred at <u>Md</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>5226 Balt Nat Hl</u> DATE SIGNED <u>10/25/56</u>			
ACTUAL SIGNATURE <u>Max J Miller</u> M.D.				PHYSICIAN'S NAME (Type) <u>Max J Miller</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max J Miller</u> ADDRESS <u>23</u>				24a. REC'D BY REGISTRAR <u>OCT 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughman</u>	

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